Khristina A. Williams, LMHC, LPC, PLLC
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Credit Card Authorization

Please complete the following information. This form will be securely stored in your clinical file and may be updated upon request at any time.

I, _______________, authorize Khristina A. Williams, Licensed Mental Health Counselor, to charge my credit card for professional services as follows:

Please Initial:

____ Recurring charges for services in the amount of $______ per visit.

____ I understand and agree that my card will be charged the full fee for cancellations with less than 24 hours notice and for appointments I miss without notice as agreed in the Counselor Disclosure Form I signed.

____ I understand and agree that my card will be charged for balances of charges not paid by me or my insurance (such as deductibles and co-pays).

____ I understand this form is valid for one year unless I cancel the authorization in writing. I will not dispute the charges ("charge back") for session I have received of appointments I missed according to the above policy.

Charges will appear on your credit card statement as "Khristina A. Williams LMHC, LPC, PLLC"

Visa MasterCard Debit Card

Card # ___________________________________

Expiration Date:______________ Verification/Security Code:______

Name as printed on card:

____

Billing Address (Street, City, State, & Zip Code):

____

Print Name____

Signature: ____Date:_________________________